make arrangements for the services described in paragraph (p)(1) of this section) ends when one of the following events occurs—

(i) The beneficiary is admitted as an inpatient to a Medicare-participating hospital or CAH, or as a resident to another SNF;

(ii) The beneficiary receives services from a Medicare-participating home health agency under a plan of care;

(iii) The beneficiary receives outpatient services from a Medicare-participating hospital or CAH (but only with respect to those services that are beyond the general scope of SNF comprehensive care plans, as required under § 483.20 of this chapter); or

(iv) The beneficiary is formally discharged (or otherwise departs) from the SNF, unless the beneficiary is readmitted (or returns) to that or another SNF by midnight of the day of departure.

(q) A home health service (including medical supplies described in section 1861(m)(5) of the Act, but excluding durable medical equipment to the extent provided for in such section) as defined in section 1861(m) of the Act furnished to an individual who is under a plan of care of an HHA, unless that HHA has submitted a claim for payment for such services.

[54 FR 41734, Oct. 11, 1989; 55 FR 1820, Jan. 19, 1990, as amended at 55 FR 22789, June 4, 1990; 55 FR 31185, Aug. 1, 1990; 57 FR 33897, July 31, 1992; 57 FR 36015, Aug. 12, 1992; 58 FR 30669, May 26, 1993; 59 FR 49834, Sept. 30, 1994; 60 FR 48424, Sept. 19, 1995; 60 FR 63188, Dec. 8, 1995; 62 FR 46037, Aug. 29, 1997; 62 FR 59101, Oct. 31, 1997; 63 FR 26308, May 12, 1998; 63 FR 35066, June 26, 1998; 64 FR 41682, July 30, 1999; 64 FR 59441, Nov. 2, 1999; 65 FR 18537, Apr. 7, 2000; 65 FR 41211, July 3, 2000; 65 FR 46796, July 31, 2000]

Subpart B—Insurance Coverage That Limits Medicare Payment: General Provisions

§ 411.20 Basis and scope.

(a) *Statutory basis.* (1) Section 1862(b)(2)(A)(i) of the Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under a group health plan with respect to—

(i) A beneficiary entitled to Medicare on the basis of ESRD during the first 18 months of that entitlement;

(ii) A beneficiary who is age 65 or over, entitled to Medicare on the basis of age, and covered under the plan by virtue of his or her current employment status or the current employment status of a spouse of any age; or

(iii) A beneficiary who is under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of his or her current employment status or the current employment status of a family member.

(2) Section 1862(b)(2)(A)(ii) of the Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under any of the following:

(i) Workers' compensation.

(ii) Liability insurance.

(iii) No-fault insurance.

(b) *Scope.* This subpart sets forth general rules that apply to the types of insurance specified in paragraph (a) of this section. Other general rules that apply to group health plans are set forth in subpart E of this part.

[60 FR 45361, Aug. 31, 1995]

§ 411.21 Definitions.

In this subpart B and in subparts C through H of this part, unless the context indicates otherwise—

Conditional payment means a Medicare payment for services for which another payer is responsible, made either on the bases set forth in subparts C through H of this part, or because the intermediary or carrier did not know that the other coverage existed.

Coverage or *covered services,* when used in connection with third party payments, means services for which a third party payer would pay if a proper claim were filed.

Monthly capitation payment means a comprehensive monthly payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient who dialyses at home or as an outpatient in an approved ESRD facility.

Plan means any arrangement, oral or written, by one or more entities, to provide health benefits or medical care

or assume legal liability for injury or illness.

Prompt or *promptly*, when used in connection with third party payments, except as provided in § 411.50, for payments by liability insurers, means payment within 120 days after receipt of the claim.

Proper claim means a claim that is filed timely and meets all other claim filing requirements specified by the plan, program, or insurer.

Secondary, when used to characterize Medicare benefits, means that those benefits are payable only to the extent that payment has not been made and cannot reasonably be expected to be made under other coverage that is primary to Medicare.

Secondary payments means payments made for Medicare covered services or portions of services that are not payable under other coverage that is primary to Medicare.

Third party payer means an insurance policy, plan, or program that is primary to Medicare.

Third party payment means payment by a third party payer for services that are also covered under Medicare.

[54 FR 41734, Oct. 11, 1989, as amended at 60 FR 45361, Aug. 31, 1995]

§ 411.23 Beneficiary's cooperation.

(a) If HCFA takes action to recover conditional payments, the beneficiary must cooperate in the action.

(b) If HCFA's recovery action is unsuccessful because the beneficiary does not cooperate, HCFA may recover from the beneficiary.

§ 411.24 Recovery of conditional payments.

If a Medicare conditional payment is made, the following rules apply:

(a) *Release of information.* The filing of a Medicare claim by on or behalf of the beneficiary constitutes an express authorization for any entity, including State Medicaid and workers' compensation agencies, and data depositories, that possesses information pertinent to the Medicare claim to release that information to HCFA. This information will be used only for Medicare claims processing and for coordination of benefits purposes.

(b) *Right to initiate recovery.* HCFA may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan.

(c) *Amount of recovery.* (1) If it is not necessary for HCFA to take legal action to recover, HCFA recovers the lesser of the following:

(i) The amount of the Medicare primary payment.

(ii) The full primary payment amount that the primary payer is obligated to pay under this part without regard to any payment, other than a full primary payment that the primary payer has paid or will make, or, in the case of a third party payment recipient, the amount of the third party payment.

(2) If it is necessary for HCFA to take legal action to recover from the primary payer, HCFA may recover twice the amount specified in paragraph (c)(1)(i) of this section.

(d) *Methods of recovery.* HCFA may recover by direct collection or by offset against any monies HCFA owes the entity responsible for refunding the conditional payment.

(e) *Recovery from third parties.* HCFA has a direct right of action to recover from any entity responsible for making primary payment. This includes an employer, an insurance carrier, plan, or program, and a third party administrator.

(f) *Claims filing requirements.* (1) HCFA may recover without regard to any claims filing requirements that the insurance program or plan imposes on the beneficiary or other claimant such as a time limit for filing a claim or a time limit for notifying the plan or program about the need for or receipt of services.

(2) However, HCFA will not recover its payment for particular services in the face of a claims filing requirement unless it has filed a claim for recovery by the end of the year following the year in which the Medicare intermediary or carrier that paid the claim has notice that the third party is primary to Medicare for those particular services. (A notice received during the